12-011.06L Oxygen: Payment for oxygen use in excess of one standard K tank, or the flow-rate equivalent of 6905 liters, every three days for a Medicaid client requires prior authorization from the Medical Services Division (see 471 NAC 7-000). The supplier shall bill the Department on Form HCFA-1500, "Health Insurance Claim Form."

12-011.06M Ambulance Services: The Department limits payment for ambulance service to medically necessary transportation required due to a medical emergency, such as an accident, acute illness, or injury. If the client's condition warrants the service, the ambulance provider shall bill the Department on Form HCFA-1500 and follow the regulations for ambulance providers in 471 NAC 4-000.

Facilities shall not claim ambulance costs on the cost reports.

12-011.06N Administration Expense: In computing the provider's allowable cost for determination of the rate, administration expense is limited to no more than 14 percent of the total otherwise allowable Direct Nursing, Direct Support Services, and Other Support Services Components for the facility.

This computation is made by dividing the total allowable Direct Nursing, Direct Support Services, and Other Support Services Components, less the administration cost category, by 0.86. The resulting quotient is the maximum allowable amount for the Direct Nursing, Direct Support Services, and Other Support Services components, including the administration cost category. If a facility's actual allowable cost for the three components exceeds this quotient, the excess amount is used to adjust the administration cost category.

12-011.06P Other Limitations: Other limitations to specific cost components of the rate are included in the rate determination provision of this system.

12-011.07 Rate Determination: The Department determines rates for facilities under two distinct methodologies - Cost-Based, Retroactively Adjusted Determination at 471 NAC 12-011.07A, and Contracting Determination at 471 NAC 12-011.07B. Providers may chose either, following the respective guidelines for the methodology chosen, except that facilities which receive grant money from the Nebraska Health Care Trust Fund (Neb. Rev. Stat. 71-7605 to 71-7622 and 71-6050) to convert nursing facility beds to assisted living beds must contract for reimbursement (see 471 NAC 12-011.07B).

12-011.07A Cost-Based, Retroactively Adjusted Determination: The Department determines rates for this methodology under the following guidelines:

12-011.07A1 Rate Period: The rate period for each facility covers services provided July 1 through June 30 of each fiscal year.

12-011.07A2 Reporting Period: Each facility shall file a cost report each year for the twelve-month reporting period of July 1 through June 30.

12-011.07A3 Care Classifications: A portion of each individual facility's rate may be based on the location and the waivered/non-waivered status of the facility. The care classifications are -

1. All Nursing Facilities in urban areas;
2. Nursing Facilities in urban areas which are non-waivered;
3. Nursing Facilities in urban areas which are waivered;
4. All Nursing Facilities in non-urban areas;
5. Nursing Facilities in non-urban areas which are non-waivered; and
6. Nursing Facilities in non-urban areas which are waivered.

12-011.07A4 Interim Rate: An interim rate, corresponding to each Medicaid resident's level of care, is a per diem paid for each inpatient day. Interim rates are paid during a rate period and then retroactively adjusted when final cost, acuity, and census data is available. Interim rates are calculated and paid during each calendar year.

The facility's interim rates consist of four components:

1. The Direct Nursing Component;
2. The Direct Support Services Component;
3. The Other Support Services Component; and
4. The Fixed Cost Component.

The interim rates are intended to approximate the final rates. Projections will utilize: (1) the immediately proceding June 30 cost reporting period; (2) available acuity information; and (3) necessary assumptions concerning inflation, and any other known factors influencing facility costs.

If the projection methodology results in interim rates which are not reflective of the estimated final rates which the facility will receive, an increase/decrease may be requested by the facility. All increase requests shall include complete written justification, documentation, and calculations necessary to determine proper interim rates. For example, an increase request which pertains to the Direct Nursing Component must include applicable salary schedules/comparisons; an increase request which pertains to the Direct Support Services and/or Other Support Services Component(s) must include supporting cost report pages for the six prior months; an increase pertaining to the Fixed Cost Component must include applicable interest, depreciation schedules, etc. The Department may disapprove all or part of a requested increase and will notify the provider of the reason(s) for the disapproval. The Department must receive a requested increase a minimum of 15 days before the effective date of service for proper review and processing. Interim rate changes are effective from the first day of the month during which the increase occurred through the end of the rate period. No increase request shall be accepted after the end of the current interim rate period.

12-011.07A5 Final Rates: Subject to the allowable, unallowable, and limitation provisions of 471 NAC 12-011.04, 12-011.05, and 12-011.06, the Department pays each facility retroactively determined per diem rates (one rate corresponding to each level of care) for the reasonable and adequate costs incurred and documented during each rate period. The rates are based on financial, acuity, and statistical data submitted by facilities for the most recent reporting period. Various care classification maximums as computed in this section are computed after initial desk audit, and are not revised based on subsequent desk audits or field audits.

The facility's final rates consist of four components:

1. The Direct Nursing Component;
2. The Direct Support Services Component;
3. The Other Support Services Component; and
4. The Fixed Cost Component.

The facility's final rates are computed as the sum of these components, subject to the rate limitations of this system. All four components are expressed in per diem amounts.

12-011.07A5a Direct Nursing Component: This component of the final rate is computed by dividing the allowable costs for nursing salaries (lines 94 through 103 of Form FA-66, "Long Term Care Cost Report") by the weighted resident days for each facility (see 471 NAC 12-013.03). The resulting quotient is the facility's "base" per diem. Each facility's base per diem is arrayed with all other facilities in the same care classification (see 471 NAC 12-011.07C), to include Classifications 2, 3, 5, and 6; the median base per diem is determined; and a maximum base per diem is computed at 125% of the median base per diem. If the maximum base per diem for waivered facilities in their respective urban or non-urban care classification is greater than the maximum base per diem for non-waivered facilities in that same care classification, the Department shall use the maximum base per diem for non-waivered facilities. Payment rates for the Direct Nursing Component for an individual facility are computed using the lower of its own base per diem, weighted for levels of care, or the maximum base per diem, weighted for levels of care.

12-011.07A5b Direct Support Services Component: This component of the final rate is computed by dividing the combined allowable costs of: the Nursing Cost Center which are not included in 471 NAC 12-011.07A5a Direct Nursing Component (lines 104 through 127 from the FA-66); raw food from the Dietary Cost Center (line 53 from the FA-66); plant utilities (lines 139 through 141 from the FA-66) and cable television service (line 143 from the FA-66) from the Plant Related Cost Center; the Activities and Social Services Cost Center (lines 164 through 183 from the FA-66); Resident Transportation - Medical from the Ancillary Cost Center (lines 211 through 218 from the FA-66); and respiratory therapy from the Ancillary Cost Center (line 203 through 210 from the FA-66), by the total inpatient days (see 471 NAC 12-011.06B) for each facility. Each facility's base per diem is arrayed with all other facilities in the same care classification, to include classifications 1 and 4; the median per diem is determined; and a maximum per diem is computed at 115% of the median per diem. Payment for the Direct Support Services Component for an individual facility is computed using the lower of its own per diem or the maximum per diem.

12-011.07A5c Other Support Services Component: This component of the final rate is computed by dividing the combined allowable costs of: the Administration Cost Center; the Dietary Cost Center, excluding raw food which is included in Direct Support Services; the Housekeeping and Laundry Cost Centers; and the Plant Related Cost Center, excluding utilities and cable television service, which are included in Direct Support Services, by the total inpatient days (see 471 NAC 12-011.06B) for each facility. Each facility's base per diem is arrayed with all other facilities in the same care classification, to include classifications 1 and 4; the median per diem is determined; and a maximum per diem is computed at 115% of the median per diem. Payment for the Other Support Services Component for an individual facility is computed using the lower of its own per diem or the maximum per diem.

12-011.07A5d Fixed Cost Component: This component of the final rate is computed by dividing the facility's allowable interest, depreciation, amortization, long-term rent/lease payments, personal property tax, real estate tax, and other fixed costs by the facility's total inpatient days (see 471 NAC 12-011.06B). Payment for the Fixed Cost Component for an individual facility is computed using its own per diem as computed above.

12-011.07A6 Retroactive Settlement: The Department shall retroactively adjust interim rates paid to an individual facility during a rate period to the allowable facility final rates as computed under the provisions of this system. The Department shall complete settlement after initial desk audits have been completed.

12-011.07B Contracting Determination: As an alternative to rates defined under 12-011.07A, facilities may elect to contract with the Department for payment for nursing facility services. However, if a facility has less than 200 certified nursing facility beds, it receives a grant from the Nebraska Health Care Trust Fund Act to convert nursing facility beds to assisted living beds, and it provides both nursing facility and assisted living levels of care, the facility must contract for their nursing facility reimbursement. The Department determines rates for this methodology under the following guidelines:

12-011.07B1 General Contracting Provisions

12-011.07B1a Effective Dates: Beginning April 1, 1999, any facility may request to contract with the Department. A contract may only go into effect on the first day of a month. A contract rate period begins the first day of the month following approval by the Department for a facility to contract, and is in effect for the following twelve months. If it is mandatory that a facility contract, the first contract rate period must begin no later than the first day of the month following the date which a Medicaid eligible resident is admitted to an assisted living bed.

12-011.07B1b Time Periods Covered: The facility's contract with the Department covers services provided during three time periods: 1) the time period which interim rates will be retroactively adjusted to contract rates. This period is from the July 1st following the June 30th Reporting Period (see 471 NAC 12-011.07A2) for which a Final Rate (see 471 NAC 12-011.07A5) has been determined for the facility, through the last day of the month before contracting begins. (Final Rates are determined after cost reports are submitted and desk audited [see 471 NAC 12-011.10 Audits] - an approximate six month time frame. Therefore, this time period is a minimum of six months, to a maximum of eighteen months); 2) the first full year contract time period. This period is from the first day of the month that contracting begins through the following twelve months; and 3) the three one-year contract time period extensions. These periods are for the following three one-year periods.

12-011.07B1c Termination from Contracting Provision: Unless a facility has received grant money under the Nebraska Health Care Trust Fund for the conversion of beds, it may terminate its contract following forty-five days notice to the Department. When a facility terminates its contract, nursing facility payment rates will be calculated under provisions of 471 NAC 12-011.07A. The rates received under contracting will continue as the facility's interim rates. If a facility terminates its contract, it is not eligible to contract again for a period of four years; if a change of ownership occurs, the four year period is waived.

A facility which has received a grant from the Nebraska Health Care Trust Fund for the conversion of beds may not terminate contracting provisions.

12-011.07B2 Notification: The facility must notify the Department of its desire to contract. Notification shall be postmarked no later than 45 calendar days before the facility's desired first contract rate period.

12-011.07B3 Cost Reporting: A cost report must be maintained for the time period which is the basis for setting contracting rates (see 471 NAC 12-011.05B5a) and is subject to audit (see 471 NAC 12-011.10 Audits). A cost report is not required for the twelve-month extension periods; however, upon request by the Department, the facility must make available revenue and cost information from audited reports for governmental facilities, federal form 990 return for non-profit facilities, and federal tax returns for proprietary facilities; revenue and cost information may not be requested more than five years after the end of each contract time period.

12-011.07B4 Department Requirements: When a facility elects to contract on a voluntary basis, the Department will approve the facility's request no later than 14 calendar days before the requested first contract rate period.

12-011.07B5 Contract Rates: A nursing facility's case-mix payment rates are determined as follows:

12-011.07B5a Cost Report Used: Level of care rates are determined from the most current, desk audited cost report. Cost reports are submitted after each June 30th Rate Period, and then desk audited (see 471 NAC 12-011.10 Audits); this is an approximate six-month time frame. Both the submission and desk audit of cost reports are required to determine the cost report used to set the facility's contract rates.

12-011.07B5b The Time Period from July 1 to the Date that Contracting Begins: Retroactive rates for this time period are computed as follows, and are no longer subject to retroactive provisions of 471 NAC 12-011.07A, when a facility elects to contract:

rates determined from the applicable cost report (see 471 NAC 12-011.07B5a Cost Report Used) are projected forward from the midpoint of that cost report period to the midpoint of July 1 to the date contracting begins using the inflation factor. Adjustments are computed using 1/12 of the factor for each month. Interim rates paid during this period are retroactively adjusted to rates thus determined.

12-011.07B5c The Time Period from the Date that Contracting Begins to the End of the following Twelve Months (the First Contract Rate Period): Prospective rates for this time period are computed as follows:

rates determined from the cost report used (see 471 NAC 12-011.07B5a Cost Report Used) are projected forward from the midpoint of that cost report period to the midpoint of the contract year using the inflation factor. Partial year adjustments are computed using 1/12 of the Factor for each month.

12-011.07B5d The Time Periods of the Next Three Twelve-Month Extensions: Prospective Rates for each 12 month extension are computed as follows:

rates from the first contract rate period are updated annually, effective the first day of each period, using the inflation factor.

12-011.07B5e Audit Adjustments: All contract rates may be adjusted based on a subsequent field audit of the cost report which forms the basis of setting rates (see 471 NAC 12-011.07B5a). Final determination of rates occurs when the field audit is finalized (see 471 NAC 12-011.11 Settlement and Rate Adjustments).

12-011.07B6 Inflation Factor: An inflation factor is determined, which, in conjunction with the applicable rates, establishes contracting rates. Each inflation factor is in effect for one year beginning each January 1. The inflation factor is computed as follows:

12-011.07B6a: From all reporting facilities, those facility's whose occupancy dropped more than 3% or increased more than 3% from the previous reporting period are excluded. Facilities whose occupancy is less than 85% are also excluded (see 471 NAC 12-011.06B Total Inpatient Days).

12-011.07B6b: Desk audited cost reports for the current and the previous cost report period for the remaining facilities are used.

12-011.07B6c: Each facility's average cost per day for each period is computed. The average cost per day is adjusted for increases/decreases in case-mix acuity.

12-011.07B6d: The adjusted cost per day increase or decrease for each facility, as computed per 471 NAC 12-011.07B6c, is arrayed from high to low, and the median increase or decrease number is the inflation factor used. However, the factor may not be less than "0%."

12-011.07B6e Exception Process: Individual facilities may request, on an exception basis, the Director of HHS Finance and Support to consider specific facility circumstance(s), which will be presented as factor(s) which warrant an exception to the computed inflation factor. It may include extraordinary influences on facility costs - for example, staff wage factors, or a specific factor, such as new construction, which affects the facility's fixed costs. The Director's decision on the facility's request is final.

12-011.07B7 Depreciation/Fair Rental Provisions: Contract rates determined under provisions of 471 NAC 12-011.07B5 include a rate amount for depreciation under the Fixed Cost Component. In lieu of the calculated depreciation, the facility is deemed to receive an equivalent rental value payment during the time period which a facility is under contracting provisions. Therefore, this portion of the rate payment is not subject to recapture of depreciation provisions (see 471 NAC 12-011.08D).

12-011.07C Out-of-State Facilities: The Department pays out-of-state facilities participating in NMAP at a rate established by that state's Medicaid program at the time of the issuance or reissuance of the provider agreements. The payment is not subject to any type of adjustment.

12-011.07D Initial Rates for New Providers: Providers entering the NMAP as a result of a change of ownership and receiving payment under 12-011.07A shall receive, as interim rates, the rates for the facility which would have been computed had there not been a change in ownership. Providers shall comply with provisions of 471 NAC 12-011.09, Reporting Requirements and Record Retention. A Final Rate and Retroactive Adjustment will be computed per 12-011.07A5 and 12-011.07A6.

Providers entering the NMAP for a reason other than a change of ownership shall receive, as interim rates, rates determined from the average interim base rate components of all providers of the same Care Classification at the time of entering. Providers shall comply with provisions of 471 NAC 12-011.09, Reporting Requirements and Record Retention. A Final Rate and Retroactive Adjustment will be computed per 471 NAC 12-011.07E and 12-011.07F.

All cost reports with less than one full year of data shall not be used in computing maximums.

12-011.07E Providers Leaving the NMAP: Providers leaving the NMAP as a result of change of ownership or exit from the program shall comply with provisions of 471 NAC 12-011.09, Reporting Requirements and Record Retention. A Final Rate and Retroactive Adjustment will be computed per 471 NAC 12-011.07E and 12-011.07F. Interim maximums in effect at the time of leaving shall be used in the computation. These cost reports shall not be used in computing maximums for the rate period.

12-011.07F Provisions for Governmental Facilities – City and County Owned Nursing Facility Proportionate Share Pool: A proportionate share pool is created to increase reimbursement to city and county owned facilities. City or county owned refers to the common meaning of ownership of the physical structure(s); the governmental entity may or may not be directly involved in the daily operation of the facility. The pool is created subject to availability of funds and subject to the payment limits of 42 CFR 447.272 (payments may not exceed the amount that can reasonably be estimated to be paid under Medicare payment principles).

The proportionate share pool is calculated by comparison of the Nebraska Medicaid care classification of residents (see 471 NAC 12-013 Classification of Residents and Corresponding Weights) to Medicare's RUG III care classifications. Each facility's Medicare rates, adjusted by the wage index published in the Federal Register are compared to equivalent Medicaid rates by resident. When more than one Medicare classification could be applicable to a Medicaid classification, an arithmetic average of the Medicare rates is computed.

The methodology shall adjust for pharmacy, laboratory, radiology, retroactive payment adjustments, and any other factors necessary to equate Medicaid to Medicare payment methodologies.

The Department shall annually submit to HCFA workpapers demonstrating the calculation of the proportionate share pool and that calculations have not resulted in payments exceeding the amount which could reasonably be paid under Medicare payment principles.

The pool for each Report Period is calculated and distributed on or about October 1 of that Report Period. Each facility's distribution amount is based on its estimated proportionate share of the pool.

12-011.07G Facility Closures: For services provided on or after July 1, 1994, when a facility closes under the following circumstances:

1. Event(s) have precipitated the movement of all residents from the facility within a period of time not to exceed 45 days (the closeout period); and
2. The facility is not certified to provide NF services for a minimum of 30 days after the final resident leaves; and
3. Cost inefficiencies result in the facility being over the Direct Nursing, Direct Support Services, or Other Support Services Component(s), then payment is made as follows:
   a. Reasonable and necessary costs which are incurred during the closeout period (the time period from the date of movement of the first resident through the final resident) will be allowed. "Unusual" costs (for example, excessive use of pool labor because permanent employees have left) must be submitted to the Department for approval;